مركز أوركيد الطبي
ORCHID MEDICAL CENTER

صحة ... ابتسامة ... جمال
Health ... Smile ... Beauty

File No: .....

Date: 24/2/19

Date: ... / ... / .....

File Number: 100170

Patient Name: Mohamed Waheed إسم المريض :

Date Of Birth (تاريخ الميلاد) : 24 / 12 / 94 Gender (الجنس) : (M) / F Marital Status:(الحالة الاجتماعية) .....

Nationality (الجنسية): Bahraini Occupation (الوظيفة) : Banker

Address (العنوان) : Al Jezzat Shj Phone No. (رقم الهاتف): 055-124-7436

E-MAIL: ..... How did you know about us: .....

Medical History التاريخ الطبي

Medical Condition الحالة الطبية	Yes/No نعم / لا	If 'YES' give details اذا كانت الاجابة نعم اذكر بالتفصيل
Recent or current drugs/Medical Treatment هل تتعاطى أي أدوية أو تتلقى اي علاجات حديثا؟	NO	
Cortisteroids/Immunosuppressant هل تتعاطى أي ستيرويدات او مثبطات للمناعة؟	NO	
Allergies هل لديك أي حساسية؟	NO	
Surgical Operations, Serious Illness هل اجريت أي عمليات جراحية او تعاني من اي امراض؟	Yes	kidney Stones removal
Cardiac surgery, Rheumatic fever, Endocarditis, Artificial heart valve, Congenital heart disease جراحة قلب، حمى روماتويد، التهاب شغاف القلب، صمام قلب صناعي، امراض القلب	NO	
High Blood Pressure, Bleeding disorders, Anticoagulants هل لديك ارتفاع في ضغط الدم، مشاكل في النزيف او تتعاطى أي مميعات للدم؟	NO	
Anemia, Leukemia (سرطان الدم) انيميا (فقر الدم)، لوكيميا	NO	
Chest disease, Asthma, Bronchitis, TB, Other امراض صدرية، ازمة تنفسية، التهاب في القصبات، السل، امراض اخرى	NO	
Renal, Urinary, Sexually transmitted disease هل تعاني من اي امراض في الكلى او امراض بولية او تناسلية؟	NO	
Pregnancy, Contraceptive pill, Menstrual problems هل انت حامل؟ هل تتعاطين اي مانع للحمل؟ هل تعانين من مشاكل في الدورة الشهرية؟	NO	
Hepatitis, Jaundice, Other liver diseases التهاب الكبد الوبائي ، الصفراء، اي امراض كبدية اخرى	NO	
Peptic ulcer, Crohn's ulcerative colitis, Other قرحة معوية، داء كرون، أي امراض معوية أخرى؟	NO	
Epilepsy, or any other neurological disease هل تعاني من الصرع او اي امراض في الجهاز العصبي؟	NO	
Thyroid Diseases, Diabetes هل تعاني من مرض السكري او امراض الغدة الدرقية؟	NO	
Other conditions هل تعاني من أي أمراض أخرى؟ HSV, HIV...etc فيروس الايدز، فيروس الحلأ البسيط	NO	

مـركـز أوركـيـد الـطـبـي
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نموذج اقرار طبي

أوافق و أسمح للطبيب بعلاج حالتي المرضية التي تم شرحها لي من قبل الطبيب المختص و المؤهل،

أتفهم أن بعض الإجراءات الطبية والتشخيصية الاضافية قد تكون ضرورية من أجل تزويدي بالعلاج الأمثل و الخدمة الافضل.

أتفهم أنه من الممكن أن يكتشف الطبيب خلال العلاج أمورا مختلفة عن ما ذكر في الفحص الأولي و التي قد تتطلب إجراءات إضافية أو مختلفة عن تلك المخطط لها.

أفوض الطبيب المعالج باتخاذ كل الاجراءات الطبية و العلاجات اللازمة و المطلوبة بحكم خبرته المهنية و العلمية.

اقر أنه لم يتم تقديم اي ضمانات او تأمين لنتائج العلاجات و الاجراءات الطبية او التجميلية المقدمة لي، كما اتفهم الاخطار و المضاعفات الناتجة عن عدم استكمال علاج حالتي المرضية.

أتفهم تماما كافة الاخطار و المضاعفات التي قد تكون مصاحبة للفحوصات والاجراءات العلاجية و الجراحية.
و ادرك ان بعض الاجراءات التشخيصية و العلاجية و الجراحية قد تؤدي الى .مضاعفات كالالتهاب أو التورم أو النزيف أو الألم أو الحساسية

أتفهم أن هناك رسوم بالحد الأدنى يجب علي دفعها مقابل الخدمة العلاجية و أن جميع الرسوم المطلوبة يجب ان تسدد بالكامل قبل الانتهاء من العلاج.

أقر أن كافة المعلومات الطبية و التاريخ الطبي الذي قدمته لدى فتحي للملف صحيحة. و اتفهم أن اي معلومات تتعلق بحالتي الصحية ستبقى سرية تماما ولا يمكن الاطلاع عليها دون موافقتي

أقر أن لدي المعلومات الكاملة لتقديم هذا الاقرار و ان هذا النموذج قد تم شرحه لي بالكامل و اني قد قرأت و فهمت جميع تفاصيله بالكامل و اني وقعت عليه بكامل ارادتي

توقيع المريض / ولي الأمر (لمن هم دون السن القانونية):

التاريخ: ... / ... / .....

Medical Consent Form

I hereby consent and authorize the doctor to treat my medical condition which has been explained to me by the qualified physician

I understand that in order to provide me with the most efficient and enhanced service, diagnostic and other procedures may be deemed necessary.

I understand that my treating doctor may discover other or different conditions, which may require additional or different procedures than those planned.

I authorize my treating doctor to perform any procedures which are advisable in their professional judgment.

I understand that no warranty or guarantee has been made to me as a result or cure just as there may be risks and hazards in continuing my present condition without treatment.

I understand that there are also risks and hazards to the performance of the diagnostic and/or surgical procedures.
I realize that common surgical or diagnostic procedures are potential for an infection, swelling, bleeding. pain or allergic reaction.

I understand that there are minimal fees to be paid per service and that all fees must be paid in full before the completion of treatment.

I consent that all medical history and information I provided in my medical file is true and I understand that any information I provide regarding my medical status will be kept confidential and anonymous.

I believe that I have sufficient information to give this consent. I certify that this form has been fully explained to me and that I have read it and I understand its' content and I sign it with all my will.

Patient's Signature/ Guardians (In case of minors):

Date: ... / ... / .....

Patient Assesment Form استمارة تقييم المريض

Vital Signs المؤشرات الحيوية

Weight (الوزن):	Kg	Height (الطول):	cm	Blood Type (فصيلة الدم) :	
Pulse (النبض):	ppm	Blood Pressure (ضغط الدم) :	/	Blood Sugar (سكر الدم) :	

Chief Complaint سبب زيارة المريض للعيادة

Teeth looks out

Disease History :التاريخ المرضي			
Allergies الحساسية			
Medications الأدوية			
Pregnancy الحمل			
Previous Surgeries, Hospitalization عمليات سابقة ، ادخال للمستشفى			
Smoking (التدخين) : Y / N	Alcohol (تعاطي الكحول) : Y / N	Drugs (تعاطي العقاقير): Y / N	

General & Clinical Findings الملاحظات العامة و السريرية

Examination الفحص

Radiography الصور الشعاعية

Diagnosis التشخيص

Upper ant- proclination
6-7 mm Overjet
Missing 65/4

File No: .....

Date: / /

Treatment Plan خطة العلاج

24/2/2019

Tt time 15 Months

Tt Cost 3500 + Retainer charge Extra

Ext - of 4

Doctor's Signature and Stamp

.....

PATIENT NAME: FILE NO#:

DATE	TREATMENT	PAYMENT	BALANCE	SIGNATURE
10/3/2019	photo, clearing done upper bondy done & 012 N.T. ligated	1000		
1/4/2019	Ofies changed for derotation Case refu to Dr Dalia for 14 Extraction	~~700~~		
20/4/2019	Extraction of 14 tooth	150	~~Dr. Dalia~~	
11/5/2019	lower bondy & 17 bondy -today in .018 slot -014 upper N.T., 012 lower	300		
13/6/2019	up 16K22 low 16	~~Del~~ 300		
1/8/2019	Same - 016 NiTi Continue derotation of 5t	300		
2/9/2019	Molar Tube Bond at 14 016 NiTi upper 016x022 lower			

REDAD DATA

cAEAIOEBAA83ODQxO | Public Data Readed Succ | SHOW READED DATA | Confirm Data

Public Data Verification report

File	Valid Signature?
Non-Modifiable Data (SF3)	False
Modifiable Data (SF5)	False
Holder Signature Image (SF7)	False
Photography	False
Home Address	False
Work Address	False

Card Holder Information

Name	Mohamed,Waheed,Mubarak,Ahmed,Busaleh	**IDN:**	784199476407202	**Mother Name:**	
Name (Ar)	محمد,وحيد,مبارك,احمد,بوصالح	**Card Number:**	089117409	**Mother Name (Ar):**	
Title:		**Nationality:**	BHR	**Family ID:**	
Title(Ar):		**Nationality (Ar):**	البحرين		
Issue Date:	17/05/2018	**Sex:**	M	**Sponsor Type:**	
Expiry Date:	31/01/2022	**Date of Birth:**	24/10/1994	**Sponsor Name:**	
Marital Status:	01	**Husband IDN:**		**Sponsor Number:**	
Residency Type:		**Residency Number:**		**Residency Expiry:**	
ID Type:	IR	**Occupation:**	11	**Occupation Field:**	00

Photo

Signature Image

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

1,050.00 **RECEIPT VOUCHER (No.REC-002919)** **Date:10-03-2019**

Receive from Mr./Mrs./M/s. **1001670 - MOHAMMED WAHEED - 971551247436**

The sum of Dhs. **One Thousand Fifty Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **1,050.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **10-03-2019**

Being **down payment done 1000 + vat total price 3500**

Made by **Rana**

Tel : + 9716 555 8337, Fax : + 9716 528 8130, e – mail : info@omc1.ae
www.omc1.ae

مـركـــز أوركـــيـــد الـــطـــبـــي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-003173)** **Date:01-04-2019**

Receive from Mr./Mrs./M/s. **1001670 - MOHAMMED WAHEED - 971551247436**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **315.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **01-04-2019**

Being **BRACES FOLLOW UP + VAT**

Made by **Hiba**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001670 - MOHAMMED WAHEED - 971551247436**

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www.omc1.ae

مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 150.00 **RECEIPT VOUCHER (No.REC-003402)** **Date:20-04-2019**

Receive from Mr./Mrs./M/s. **1001670 - MOHAMMED WAHEED - 971551247436**

The sum of Dhs. **One Hundred Fifty Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **150.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **20-04-2019**

Being **Extraction (Simple)**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001670 - MOHAMMED WAHEED - 971551247436**

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-003650)** **Date:11-05-2019**

Receive from Mr./Mrs./M/s. **1001670 - MOHAMMED WAHEED - 971551247436**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **315.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **11-05-2019**

Being **BRACES FOLLOW UP + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001670 - MOHAMMED WAHEED - 971551247436**

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004038)** **Date:13-06-2019**

Receive from Mr./Mrs./M/s. **1001670 - MOHAMMED WAHEED - 971551247436**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **315.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **13-06-2019**

Being **BRACES FOLLOW UP + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001670 - MOHAMMED WAHEED - 971551247436**

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004591)** **Date:01-08-2019**

Receive from Mr./Mrs./M/s. **1001670 - MOHAMMED WAHEED - 971551247436**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **315.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **01-08-2019**

Being **BRACES FOLLOW UP + VAT**

Made by **Hiba**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001670 - MOHAMMED WAHEED - 971551247436**

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ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-004945)** **Date:02-09-2019**

Receive from Mr./Mrs./M/s. **1001670 - MOHAMMED WAHEED - 971551247436**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **315.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **02-09-2019**

Being **BRACES FOLLOW UP + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001670 - MOHAMMED WAHEED - 971551247436**

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مركز أوركيد الطبي
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AED 315.00 **RECEIPT VOUCHER (No.REC-006713)** **Date:25-12-2019**

Receive from Mr./Mrs./M/s. **1001670 - MOHAMMED WAHEED - 971551247436**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **315.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **25-12-2019**

Being **braces follow up + vat**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001670 - MOHAMMED WAHEED - 971551247436**

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مركز أوركيد الطبي
ORCHID MEDICAL CENTER

AED 315.00 **RECEIPT VOUCHER (No.REC-005698)** **Date:29-10-2019**

Receive from Mr./Mrs./M/s. **1001670 - MOHAMMED WAHEED - 971551247436**

The sum of Dhs. **Three Hundred Fifteen Dirhams and Zero Fils Only**

By Cash **0.00** / By Credit Card **315.00** / By Cheque **0.00** / By Bank Transfer **0.00** / By Allocated **0.00**

Bank: Cheque No. Date: **29-10-2019**

Being **BRACES FOLLOW UP + VAT**

Made by **Rana**

1.Any Advance refund will be accepted within 48 hours for 25% of deduction from the total amount.
2.Treatment includes lab cost is non-refundable.
3.After 48 hours No refundable accepted

Confirmed by : **1001670 - MOHAMMED WAHEED - 971551247436**

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